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IN THE NEWS

Obamacare Startup Oscar Said Valued at $3.2 Billion in New Round

Oscar Insurance Corp., the health insurer focused on selling Obamacare plans, raised $165 million as investors bet the company can disrupt entrenched rivals, despite years of financial losses.

The insurer, whose co-founders include Joshua Kushner and Mario Schlosser, was valued at $3.2 billion in the round, a person familiar with the matter said. The person asked not to be identified because the details aren't public. The funding round was led by Founders Fund, and boosts the company from a previous valuation of $2.7 billion it garnered in early 2016.

Oscar expanded this year, signing up about 250,000 people as it entered new markets including Tennessee and Ohio, even as President Donald Trump sought to repeal the Affordable Care Act, and many of the company's larger rivals pulled back. The company said it will use the funds to expand into four to five new cities a year, and that it may sell other kinds of health insurance.

Other firms are eyeing opportunities in health care, too. Amazon.com Inc., JPMorgan Chase & Co., and Berkshire Hathaway Inc. said earlier this year they'd start a venture to improve health care, starting with their own workers

Walmart Is Said in Talks with Humana for Deeper Partnership

Walmart Inc. is in talks with health insurer Humana Inc. for a closer partnership to provide health care to consumers at home and prevent illness, according to a person familiar with the matter.

Health-care spending accounted for about 18 percent of the U.S. economy last year, and continues to surge with an aging population, pricey medications, and a complex regime of reimbursements and middlemen. Companies have been trying to address some of the market's inefficiencies by forging alliances or getting bigger: Cigna Corp. is acquiring Express Scripts Holding Co. for $54 billion, and CVS Health Corp. is buying Aetna Inc. for $68 billion.

Walmart and Humana have explored a wide range of options including a merger, though an outright combination isn't likely at this point, said the person, who asked not to be identified discussing private information. The Wall Street Journal reported Friday that Walmart was in early talks to acquire Humana.

An acquisition of Humana's size -- $37 billion -- would be rare for Walmart, which has mostly been focused on buying e-commerce companies, including last year's deals for Bonobos Inc. and ModCloth. But the company still gets plenty of shoppers in physical stores who rely on its 4,700 pharmacies in the U.S. Like drugstore chain CVS, Walmart could use a partnership with an insurer, or even a merger, to take on a more powerful role in the delivery of medications to consumers.

Walmart and Humana already work together on prescription drug plans for individuals in the U.S. Medicare program. The plans offer some prescriptions for as little as $1, as long as customers pick up their drugs at a Walmart or Sam's Club. Walmart could use a closer tie-up to steer more of Humana's customers to its stores through its drug coverage arrangements.

Stores can also be a convenient place for individuals to get care, and both CVS and Walmart have clinics in some locations. The rising cost of health care has captured the attention of some of corporate America's biggest titans. Amazon.com Inc., JPMorgan Chase & Co. and Berkshire Hathaway Inc. announced plans earlier this year to set up a business to improve their employees' care. Berkshire Chairman Warren Buffett called high health costs a "tapeworm" afflicting the U.S. economy.

Walmart has been buying health care for its workers directly from providers in six different regions -- bypassing insurers who usually negotiate with doctors and hospitals. The idea has been to squeeze out middlemen and drive down costs in the same way that the retail giant's tough bargaining has brought down prices for shoppers. Walmart has been testing its new plans, known as accountable-care organizations, or ACOs, for two years. ACOs, which can be set up by employers on their own or with an insurer's help, limit consumers to a smaller group of care providers.

Author of Obamacare Fix Not Giving Up

The effort to pass legislation to bolster Obamacare's insurance markets isn't over, one of the House Republicans leading the charge told Bloomberg Law. Rep. Ryan Costello (R-Pa.) plans to restart negotiations with Democrats on a way to reduce premiums for those who purchase insurance on the individual market when Congress returns in April. He said March 27 he's hopeful he can find a compromise both parties can rally around. Costello sponsored a bill that became central to the latest plan to authorize billions of dollars for a federal reinsurance program and Obamacare's cost-sharing reduction (CSR) payments.

The once-bipartisan movement to stabilize costs for those on the individual market fell apart due to a debate over abortion language in the proposal just days ahead of when Congress passed a long-term government spending bill that was widely considered the last likely vehicle for any Obamacare fix. "I would hope there's a way for Democrats to see that we can do CSRs and reinsurance with Hyde protections," Costello said, referring to the Hyde amendment, which restricts federal funds from going to abortion services.

Insurers are already setting premium rates for 2019, America's Health Insurance Plans, the insurance lobby, warned this week. Many are expected to announce double-digit premium increases in the coming months. Leading Republicans and Democrats blame each other for failing to get an Affordable Care Act fix into the omnibus funding measure that kept the government open. Some lawmakers are skeptical members of the two parties can bridge the divide between them on whether to restrict ACA funds from going to plans that cover abortions.

Costello, however, contends there must be some middle ground on the issue and he's hoping to find it before insurance rates are set later this year. Costello announced March 25 he will not seek re-election in November because his district was redrawn by order of Pennsylvania's state supreme court. The Cook Political Report reported his district now favors a Democratic candidate; before the map was drawn it was considered a toss-up between the two parties.

Sen. Lamar Alexander (R-Tenn.) told Bloomberg Law March 22 he sees "no prospect" for a deal on measures to head off expected increases in health insurance premiums for those on the individual market after his counterpart in negotiations, Sen. Patty Murray (D-Wash.), the top Democrat on a panel Alexander chairs, blocked an amendment to the omnibus spending bill that would have authorized the ACA's cost-sharing reduction payments and created a $30 billion reinsurance program. Alexander and Murray, chairman and top Democrat on the Senate's health committee, have been negotiating a bipartisan Affordable Care Act fix since October but they couldn't reach a final deal for the spending bill, which passed Congress in the early hours of March 23.

Democrats weren't happy when Alexander and Sen. Susan Collins (R-Maine) announced they'd reached a deal with Costello and Rep. Greg Walden (R-Ore.), chairman of the influential House Energy and Commerce Committee, on an ACA fix that explicitly prohibited the cost-sharing funds and reinsurance funds from going to plans that cover abortion services. Their proposal was similar to a bill Costello introduced in the House (H.R. 4666) in December. Staff for Senate Democrats and Republicans were still negotiating a different deal just days before Alexander announced he was backing the Collins/Costello/Walden plan, two Senate aides told Bloomberg Law March 27.

Democrats, led by Murray, said they couldn't vote for the bill because it contained "massive expansions of restrictions on women's access to safe, legal abortion." Democrats also didn't want to support the proposal because it would codify part of a Trump administration rule to expand access to some short-term insurance plans, often derided by opponents as "junk insurance" because they don't have to meet the ACA's coverage

rules. Alexander defended the abortion restrictions as language typical for any appropriations bill. ACA supporters, however, warned it could drastically reduce the availability of insurance that covers abortion services for people on the individual markets, Marjorie Connolly, a former spokeswoman for the Department of Health and Human Services during the Obama administration who is now a spokeswoman for the left-leaning Protect Our Care, told Bloomberg Law. "This language could've stopped all abortion coverage" on the individual market, she said.

The ACA doesn't require plans to cover abortion services like it does for other health services the law labels as essential and prohibits cost-sharing reductions from subsidizing abortions, according to a Kaiser Family Foundation analysis. Half of all states ban the coverage of abortion on ACA marketplace plans sold within their borders.

The ACA stabilization plan backed by Costello and Alexander would create a disincentive for insurers to offer abortion coverage for plans on the individual market because those plans wouldn't qualify for cost-sharing or reinsurance funds, Kaiser found.

INSIDE CMS

HHS Names Former Pharma Executive as Drug Price Adviser

A former executive at CVS Health and Pfizer is the new adviser on drug price reforms at the Department of Health and Human Services.

HHS Secretary Alex Azar named Daniel Best as the senior adviser to the secretary on drug pricing reforms. Azar in a March 29 statement added that bringing down the high cost of prescription drugs is one of his top four initiatives for transforming health care, along with fighting the opioid crisis, addressing the cost of insurance, and moving health care to a value-based system.

Best is an expert on the Medicare Part D program, the largest single payer for prescription drugs, according to the HHS. He recently worked as corporate vice president of industry relations at CVS Health's Medicare Part D business. Before working at CVS, which offers pharmacy benefit and pharmacy services, Best worked at drug manufacturer Pfizer.

Best joins Azar, another pharmaceutical industry veteran, at the HHS. The hiring of Best comes amid a donnybrook over drug pricing that pits insurers and pharmacy benefit plans against manufacturers over who is to blame for high drug prices in the U.S. And critics of the Trump administration have faulted it for not following through on tough talk to drive down prices. But on March 19, President Donald Trump said he'll hold a news conference in about a month on drug prices, and Azar at the time said the administration will seek discounts from "middlemen" in the industry, but didn't elaborate on what types of companies would be affected.

Sen. Claire McCaskill released a report March 26 on price increases for commonly prescribed branded medications. Among the Missouri Democrat's findings is that while 48 million fewer prescriptions were written for the top 20 most commonly prescribed brand-name drugs for seniors between 2012 and 2017, the total sales revenue resulting from these prescriptions increased by almost $8.5 billion during the same period. McCaskill is the top-ranking Democrat on the Senate Homeland Security and Governmental Affairs Committee.

The HHS leader also named an adviser to fight the opioid abuse epidemic. Brett Giroir, who is already the assistant secretary for health, will help coordinate policy to fight the epidemic. Giroir's duties will be to coordinate the HHS's efforts across the administration against the opioid crisis.

According to the Centers for Disease Control and Prevention, on average, 115 Americans die every day from an opioid overdose. About 66 percent of the more than 63,600 drug overdose deaths in 2016 involved an opioid, according to the CDC.

Medicaid Drug Payment Scrutiny Picking up Steam

Medicaid's system for purchasing drugs for coverage is in the cross-hairs as momentum grows to contain spending. Congressional leaders with the Senate Finance and House Energy & Commerce committees are calling for more details on oversight of the drug rebate program, especially how the prescriptions are classified as either a brand-name innovator or a generic drug. A host of lawmakers across both sides of the aisle are "troubled" by possible overcharging and gaps in how officials monitor the program, they told CMS Administrator Seema Verma in a letter.

Sens. Orrin Hatch (R-Utah) and Ron Wyden (D-Ore.), among others, want to know more about the guardrails in place to prevent inappropriate determinations—and if more are needed. "We are deeply concerned about these potentially longstanding weaknesses in the agency's oversight of the accuracy of drug classifications" in the drug rebate program, the lawmakers wrote. "Further steps appear to be needed to protect taxpayer dollars and strengthen the Medicaid program."

A recent Department of Health and Human Services inspector general report found the safety-net health insurance program may have missed out on $1.3 billion because of the misclassification of 10 medicines. Meanwhile, Medicaid directors and managed care plans, as well as a congressional advisory group, have been working to find ways to overhaul the pricing structure, warning of its growing cost to the $550 billion safety net. The program spent about $29 billion on prescription drugs in 2015, an increase of 14 percent over the previous year, according to the Medicaid and CHIP Payment and Access Commission.

The drug industry contends that Medicaid programs already have significant leeway and tools to keep spending down, including the rebates. And prescription drugs only make up 3.5 percent of the spending, according to the Pharmaceutical Research and Manufacturers of America, the industry's lobbying wing. PhRMA is "still reviewing" the congressional letter and watchdog report, spokeswoman Juliet Johnson told Bloomberg Law. But the lobby does "strongly believe Medicaid rebates are an effective way to keep costs down for states, providing them with an average 63 percent discount on brand name drugs."

The congressional letter to the Medicaid agency doesn't mention a specific company, but in 2017 Mylan NV reached a $465 million final settlement of a U.S. case that claimed the drugmaker defrauded taxpayers by misclassifying its allergy-shot EpiPen product as a generic drug. The settlement, announced last August, resolves claims that Mylan misclassified EpiPen to avoid paying rebates owed to the government. Mylan's revenue was $11.9 billion in fiscal 2016, according to Bloomberg Government.

Lawmakers are asking which types of drugs, such as cancer or diabetes medicines, were put in the wrong category. They also want the Medicaid agency to commit to a deadline for reviewing those drugs and to "take appropriate action," including strengthening Centers for Medicare & Medicaid Services oversight of the process for determining the drug type. Medicaid advisers are also eyeing suggestions to Congress to bolster HHS controls over prescription drug classification such as financial penalties and the ability to

reclassify inaccurate drugmaker determinations. The CMS can't currently mandate changes to drugmakers' reporting on the classifications, according to the HHS OIG.

Under the current system, drugmakers discount the medicines for Medicaid by nearly 50 percent, depending on the type of drug, according to MACPAC. Those who make both an authorized generic and a brand name are required to merge the two average costs. The advisers voted earlier in March to recommend scrapping that calculation, noting that it means a manufacturer can lower the rebate amount by blending the prices. Brand rebates are set to 23.1 percent of an average manufacturer price or more if a drugmaker gave a better price to another payer, while the discounts only have to be 13.1 percent off the average price for generic medicines. Medicaid managed care plans "support efforts to ensure pharmaceutical companies are complying with requirements to submit accurate data," Jeff Myers, president and CEO of Medicaid Health Plans of America, told Bloomberg Law in a statement.

The CMS "takes seriously its responsibility to oversee" the drug rebates and reviews every covered drug's classification each quarter "to keep manufacturers honest," an agency spokesperson told Bloomberg Law in a statement. "We are continuing to do as much as current statutory authority allows to protect the integrity of the Medicaid program," the CMS said. That includes recent regulatory steps to "clarify" reporting requirements and to tell drug companies when the information they're providing is wrong.

The White House in its proposed fiscal 2019 budget called for health officials to clarify the Medicaid definition of brand and over-the-counter drugs "to ensure appropriate" rebates. The Trump administration projects that the move would save $319 million over the next decade. Steps toward changing the Medicaid drug discount system could also have repercussions for other pushes to change Medicaid's pricing structure for its drug benefit. MHPA, for example, is calling for an overhaul of the drug rebate program but has yet to release the full proposal. The group represents 165 health plans including key insurers such as such as Aetna, Centene, UnitedHealthcare, and WellCare. Together the plans cover 28 million beneficiaries.

Feds Cracking Down on State Medicaid Programs

State Medicaid programs face a wave of enforcement actions after a recent audit uncovered millions of dollars in improper reimbursements made to New Jersey's Medicaid agency. Medicaid programs depend on federal reimbursements to stay afloat, and increased scrutiny by government auditors could spell financial disaster.

The audit uncovered widespread deficiencies in claims the New Jersey program submitted to the federal government for reimbursement for services provided to state residents, and recommended that New Jersey pay back the federal government $54.7 million. The New Jersey report is the seventh state Medicaid-based report the Health and Human Services Office of Inspector General has issued in 2018, and all have uncovered problems ranging from defects in Medicaid nursing home surveys to improper federal reimbursements for Medicaid physician-administered drugs. In addition to New Jersey, the reports addressed programs in New York, Arkansas, California, Arizona, and North Carolina.

Overall federal outlays for Medicaid topped $349.8 billion in 2015, up 16 percent from the previous year, according to the government's most recent actuarial report on the program. Federal payments accounted for 63 percent of the total spending on Medicaid in 2015 ($553.8 billion), according to the report. The current work plan for the OIG has several more audits in the works focused on Medicaid spending and state oversight, including one on Medicaid payments for school-based health services and another on how funds are used by Medicaid managed care organizations, Ellyn Sternfield, a health-care attorney with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo PC in Washington, told Bloomberg Law. Upcoming audits will

focus on how states determine who's eligible for Medicaid and how effective state programs are in reporting and collecting Medicaid overpayments. Sternfield previously served as the director of the Oregon Department of Justice's Medicaid Fraud Control Unit.

Of the five states with the highest Medicaid enrollment—California, New York, Illinois, Texas, and Florida—the first three expanded their programs through the Affordable Care Act, boosting patient populations and increasing their federal reimbursements. High enrollment states may be at a particular risk of enforcement because they have such huge patient populations and rely on the federal government for a significant portion of their funding.

The $54.7 million figure is a very large amount for a state Medicaid program to be asked to refund, and it should be a wake-up call for other states that have Medicaid-covered partial hospitalization services, Judith Waltz, a health-care attorney with Foley & Lardner LLP in San Francisco, told Bloomberg Law. Waltz works on a variety of Medicare and Medicaid overpayment cases and previously served as assistant regional counsel for the Department of Health and Human Services in San Francisco.

It's likely that the New Jersey Medicaid program will look to the hospitals to refund the deficient claims to the state, Waltz said, so the report should be reviewed by providers working in state Medicaid programs as well as the state Medicaid programs themselves. Waltz said she also assumed that the New Jersey Medicaid program will step up provider oversight, but increased oversight can raise costs for both the state and providers.

Partial hospitalization services have always been difficult to provide and document appropriately, and have been the focus of many false claims cases, Waltz said. The OIG's report noted that it was a follow-up to an earlier report examining adult partial hospitalization, which suggests that states that have had trouble with their adult program should be on the alert because of the new report, Waltz said.

It's increasingly likely that Medicaid programs in general will be facing more scrutiny over the next few years than they have historically, Waltz said. The Centers for Medicare & Medicaid Services Medicaid Integrity Program auditors are in high gear, in conjunction with state program integrity functions, and the ACA gave states more enforcement tools, Waltz said. "Medicaid programs receive a lot of federal money, and there is a lot of talk about a need for Medicaid reform, which suggests more scrutiny for fraud, waste, and abuse," Waltz said. Federal Medicaid Integrity Program contractors review provider activities, audit claims, identify overpayments, and educate providers on proper behavior.

The New Jersey audit doesn't relate to any outright fraud but is instead concerned with what Sternfield referred to as "government red tape." The audit doesn't allege that any hospitals billed for children's services that were never provided, and there are no allegations children received sub-par treatment, Sternfield said. The states are charged with administering the Medicaid program and making sure that providers comply with state standards, Sternfield said. The New Jersey report highlighted that the state and the federal government had different licensing standards for facilities providing outpatient hospital services.

LEGISLATIVE/REGULATORY

Congress Probing Hospitals Over Quality, Safety

Congress is turning its focus on bolstering hospital quality and safety in Medicare and Medicaid.
The House Energy & Commerce Committee is probing accrediting organizations and regulators of the insurance programs for seniors and the poor, in a bid to ensure that participating hospitals that oversee them

are up to par. Lawmakers are concerned about both the sufficiency of federal oversight and of the process used by agencies to review most providers' compliance.

The health-care sector, including the top U.S. health official Alex Azar, has become increasingly focused on speeding up a movement toward paying for value not volume amid a system that reached a cost of $3.3 trillion in 2016 yet carried hefty risks for patients. Medical errors are the third leading cause of death in the U.S., according to a study from the Johns Hopkins University School of Medicine. And the Leapfrog Group, a nonprofit health-care quality advocate, estimates a Medicare patient faces a 25 percent chance of injury or death while in the hospital. Analysts told Bloomberg Law the two programs carry such a wide footprint—55.5 million Medicare and nearly 75 million Medicaid enrollees—that lawmakers and administrators could be using them to drive the change. "As a congressional committee in charge of overseeing the implementation of Medicare, you know that changes you might implement in future are pretty much going to be adopted by every hospital in the country," John Feore, a director at consultant Avalere Health in Washington, said. "Certainly you want to make sure what you're doing is going to have a positive impact." Further, the push comes in the wake of failed efforts to repeal and replace Obamacare and revamp safety-net programs.

"In the run-up [to the legislative bills]... there were a lot of stories about patients not getting appropriate care or lots of patients complaining about the quality of care they did receive," Jason Mehta, a partner with Bradley Arant Boult Cummings LLP in Tampa, Fla., told Bloomberg Law. Mehta was formerly a federal prosecutor at the Department of Justice. He added that it's a "defining moment" for health care: "Against that backdrop Congress is rightfully asking questions about whether providers are providing not just competitively priced health care but also quality health care," Mehta said.

The House panel asked the Centers for Medicare & Medicaid Services for its contracts and communication with state agencies on their certifications and surveys of providers, as well as details on complaints since 2012 of patient harm or misconduct and how they were handled. The letter to CMS Administrator Seema Verma also asks for documents on the differences in findings between reviews conducted by state validation surveys and hospital surveys conducted by private accrediting organizations.

The private accreditation organizations missed 39 percent of "'condition level' deficiencies"—the most serious—in their findings that were later discovered by state agencies, according to CMS figures cited by the lawmakers. Most hospitals though (89 percent) use this method to prove they're meeting federal standards on patient safety for the purposes of Medicare and Medicaid reimbursement.

Lawmakers are also asking the accreditors—including the Healthcare Facilities Accreditation Program (HFAP), the Center for Improvement in Healthcare Quality, DNV GL Healthcare, and the Joint Commission—for information on their review processes. Specifically, the lawmakers want to see copies of hospital accreditation applications, performance reviews, corrective action plans and their responses, and any exchanges with the CMS for disparities in hospital survey rates. Feore said the panel is looking at program standards "from the angle that some hospitals may be failing to achieve those requirements" and hinting at that by suggesting some accrediting bodies "may not be performing up to their contracts or to their charge." Opportunities for Providers? Both HFAP and the Joint Commission told Bloomberg Law they'd answered the House committee request. "We view this as an opportunity to share more on the work we do to improve health care quality and patient safety by facilitating high reliability," Katherine Bronk, a spokeswoman with the Joint Commission, said in a statement.

Angela FitzSimmons, a spokeswoman for HFAP, noted that its hospital evaluations look for "improvement" opportunities, not just meeting the standards for participating in Medicare and Medicaid. Mehta said this

focus on provider safety and quality will remain a priority for both Congress and the Trump administration, possibly moving into nontraditional metrics for reimbursement in the health-care programs—but that could be a boon for hospitals if they're flexible, he said. "It's a real opportunity and also a real risk to be addressed about what it is Congress and the executive branch are looking to: It's an opportunity also to really differentiate yourself from peers," he said.

Health-care analysts noted that the move is likely a harbinger for more efforts in this space to come. Feore said addressing the conditions of participation for Medicare and Medicaid is a cornerstone on the way toward a "value-based world" and changes to more advanced types of quality measures. The standards have been in place since the late 1960s; this push is geared toward ensuring they're "actually meaningful and providers are aware of their obligations and that they're even aware of potential deficiencies they could correct if they knew about them."

Nancy Foster, vice president of quality and patient safety policy at the American Hospital Association, said hospitals "are committed to patient safety every day and for decades have worked closely with accrediting organizations to improve the quality and safety of care for the patients and communities we serve." The private accrediting bodies "continuously strive" to pinpoint strategies for health system improvement, she said in a statement to Bloomberg Law. "Coupled with hospitals' own internal quality improvement activities, this has led to measurable improvements for our patients," she said.

Democrats Want Trump to Pull Health-Care Conscience Regs

The Trump administration's plan to protect health-care workers' consience rights would lead to discrimination against patients including gay people and should be withdrawn, according to attorneys general of 18 states.

The group of Democratic state attorneys general, including New York's Eric Schneiderman and Illinois' Lisa Madigan, called on the administration to pull a proposed HHS rule designed to protect statutory conscience rights in health care, arguing that the rule is unconstitutional and would increase discrimination. The attorneys general said March 27 the Health and Human Services rule would be particularly onerous for marginalized patients like lesbian, gay, bisexual, and transgender people.

The letter opens up another front in the battle over the regulations. Several public interest law firms have indicated that they are likely to sue the HHS to block the rule once it's final.

The regulation proposed by the HHS "will needlessly and carelessly upset the balance that has long been struck in federal and state law to protect the religious freedom of providers, the business needs of employers, and the health care needs of patients," the state AGs said in a their letter.

"This Proposed Rule is unsupported by the federal health care conscience laws it purports to implement; conflicts with federal statutes regarding emergency health care, religious accommodations, and comprehensive family planning services; undermines the States' health care policies and laws; would lead to status-based discrimination against patients; and would violate both the Spending Clause and the Establishment Clause of the United States Constitution," according to the letter.

The proposed regulation, issued two months ago, would give stepped-up enforcement power to a new division within the HHS's Office for Civil Rights designed to protect freedom of religion and conscience. The office will investigate health-care facilities' and workers' complaints that they are being compelled to

participate in abortions, sterilizations, and assisted suicides in violation of their religious beliefs or moral convictions.

Roger Severino, director of the HHS's Office for Civil Rights, previously said the rule was intended to ensure doctors and nurses aren't "bullied out of the practice of medicine simply because they object to performing abortions against their conscience." Shortly after the proposal was released, anti-abortion groups, like the Becket Fund and Alliance Defending Freedom, immediately rallied behind the development. Alliance Defending Freedom Legal Counsel Elissa Graves, in a press release, commended the "Trump administration for its leadership in protecting women's health and defending the sanctity of life."

The 18 Democratic attorneys general who signed the March 27 letter are from New York, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington. The Washington, D.C., attorney general also signed the letter. March 27 was the due date for comments on the rule, which was published Jan. 26.

Democrats Want Probe on Medicaid Work Requirement Costs

Two leading congressional Democrats want a government watchdog to study the costs of creating new Medicaid work requirements and other conservative-friendly changes to the public insurance program. The Trump administration has signaled it's willing to allow states to test new models of their public health insurance programs for the poor that include work requirements for beneficiaries. Three states—Arkansas, Indiana, and Kentucky—have installed work requirements for their Medicaid recipients, and seven more states have spending requests for similar requirements.

These changes are central to Republican efforts to remake Medicaid, which expanded coverage in 32 states under the Affordable Care Act, and restrict the program to those who can't find employment because they're elderly, disabled, or are children. However, critics on the left have noted, new requirements bring administrative burdens as well.

Rep. Frank Pallone Jr. (D-N.J.) and Sen. Ron Wyden (D-Ore.) sent a letter to the Government Accountability Office requesting that the watchdog agency study the administrative costs associated with these state Medicaid waivers. The pair warned "restrictive" requirements for public assistance programs meant to cut costs often incur heavy administrative costs. They released the letter March 28.

If the Centers for Medicare & Medicaid Services "continues to approve work requirements and other restrictions on Medicaid, the consequences could be severe for federal spending and the sustainability of the Medicaid program," the pair told the GAO. Pallone is top Democrat on the House Energy and Commerce Committee, while Wyden is the top Democrat on the Senate Finance Committee.

The pair point out that the changes Kentucky is making to its Medicaid program are expected to cost the state more than $370 million over the next two years, largely for administrative costs. Kentucky claimed in its waiver request the changes will save the state and the federal government more than $2 billion over the next five years, largely due to a decline in adult enrollment over that time period.

Some states, like Wisconsin, have submitted waivers to the CMS that contain requirements never before included in Medicaid programs, such as drug testing and eligibility time limits. Some of these requests apply to the Affordable Care Act's expansion population, while others would affect the traditional Medicaid population.

Congress Grappling With Privacy Questions in Opioid Crisis

Changes to federal health privacy rules restricting doctors' access to drug treatment records could play a major role in Congress's response to the opioid epidemic in the coming months.

Lawmakers recently passed a measure meant to help better flag for doctors when a person they're treating has a history of substance use. Jessie's Law was created for a woman who died from an overdose after being given a prescription for oxycodone despite telling her doctor she was recovering from an opioid addiction. But the bill doesn't solve the problem at the heart of the issue: Hospitals and doctors often can't keep substance use records with the rest of a patient's health history, leaving them without crucial information. A coalition of behavioral health and information management groups wants to change that by aligning federal health privacy rules so all health data must be treated the same.

"By aligning, we can get better coordination for patients, avert risk, and give them better care," Duanne Pearson, senior director for federal affairs for Premier Inc., an alliance of thousands of hospitals and physicians, told Bloomberg Law.

Some substance abuse treatment providers, however, worry relaxing federal privacy rules could discourage some people from seeking drug addiction treatment out of fear their records will end up the wrong hands. Substance abuse treatment records are protected by a 40-year-old statute commonly referred to as Part 2, which generally requires specific, written consent by the patient in order to be shared among doctors and hospitals. Most of a person's other health data can be shared among the health-care providers who treat them for treatment, payment, or operations purposes.

To comply with these stricter rules most hospitals or doctors' offices that keep substance use treatment data simply separate the files, with the result that drug treatment data are often not shared among doctors, Lauren Riplinger, senior director of federal relations for the American Health Information Management Association, told Bloomberg Law. Electronic records typically can't separate the data either, so most drug treatment records are often left on paper while the rest of a person's health history is digitized.

This means doctors sometimes don't know if their patients have a history of drug or alcohol abuse, even if they've gotten treatment, and hospitals and doctors in integrated care models are missing crucial information, Riplinger said. This separation of the data also means some drug treatment centers are struggling to participate in some integrated care models, for which they have to share their patient data. It also means researchers generally don't have access to substance use disorder records. The Centers for Medicare & Medicaid Services didn't include roughly 4.5 percent of inpatient Medicare claims and 8 percent of Medicaid claims in key research files because they contained some substance use disorder diagnoses, according to a 2015 study published in the New England Journal of Medicine. AHIMA is part of a group of more than 30 health-care organizations including the American Hospital Association and the Blue Cross Blue Shield Association, known as the Partnership to Amend 42 CFR Part 2, looking to alter federal privacy rules. Lawmakers appear eager to tackle the problems around the opioid epidemic, which contributed to 116 deaths each day in 2016, but wary of overhauling federal privacy rules.

The House's champion to alter Part 2 rules, Rep. Tim Murphy (R-Pa.), left Congress late last year after a scandal. His proposal to alter federal privacy laws has been taken up by Reps. Markwayne Mullin (R-Okla.) and Earl Blumenauer (D-Ore.), who have since limited the changes Murphy has proposed.

House lawmakers are considering Mullin's bill to allow doctors and hospitals to share substance abuse records for treatment purposes, but not for payment or other purposes. This limiting of the bill to just treatment purposes was meant to ease the concern of some lawmakers, Pearson said. However, Reps. Frank

Pallone Jr. (D-N.J.) and Gene Green (D-Texas) still voiced concern the legislation would relax federal privacy laws too much during a recent House Energy and Commerce Committee hearing on the opioid crisis. Advocates are now weighing if they can return the bill to its original form, Pearson said. The House is expected to take up opioids legislation by Memorial Day, he said.

Hospital groups have warned the limitation might not make a difference in sharing substance use disorder records because of the difficulty in separating treatment and payment purposes. America's Essential Hospitals, in a letter to the House Energy and Commerce Committee ahead of a March 22 hearing on the opioid crisis, warned this would mean doctors couldn't share treatment data for care coordination programs or for prescription drug monitoring programs.

AROUND THE STATES

States Moving to Create Obamacare Stabilization Plans

States are moving along with plans to set up their own programs to reduce premiums in the 2019 Obamacare markets after the collapse of a federal market stabilization plan. Wisconsin, Maryland, and Hawaii are the furthest along with plans to set up reinsurance programs that provide health insurers with funding to cover high-cost claims, and the District of Columbia, Rhode Island, and Vermont are considering proposals to create their own individual mandates, health-care experts told Bloomberg Law.

Without measures to stabilize the individual markets in 2019, premiums could once again rise sharply after double-digit increases in 2017 and 2018, and people on both sides of the political aisle are warning the markets could collapse. But time is running out as many state legislatures are about to end for the year. A market stabilization plan put forward by Republicans was dropped from the fiscal 2018 omnibus spending bill enacted March 23 because Democrats objected to a provision in the plan that would have blocked billions of dollars in cost-sharing payments and reinsurance funds from being used to support any health plans that cover abortions.

The Maryland House of Delegates and the state Senate have approved legislation that would create a reinsurance program for 2019, and Gov. Larry Hogan (R) is expected to sign it, Maryland Sen. Thomas Middleton (D), chairman of the state Senate Finance Committee and primary sponsor of the Senate bill, told Bloomberg Law March 26.

Between $300 million and $400 million would be provided for payments to health insurers to cover high-cost claims under the legislation, Maryland Insurance Commissioner Al Redmer told Bloomberg Law March 26. That would reduce premiums by about 20 percent, he said. That in turn would reduce the amount the federal government must pay under the Affordable Care Act to cover premium tax credits for exchange enrollees with incomes between 100 percent and 400 percent of the federal poverty level. Without the legislation, Maryland would potentially face premium increases of as much as 50 percent in 2019, said Redmer, a Republican appointed by Hogan. Such increases could be "the catalyst for the market to implode," he said.

Moreover, that could have "catastrophic results for the group market and even self-funded plans," Redmer said. Under Maryland's all-payer system, the state negotiates rates hospitals can charge to health insurers. A spike in premiums could lead to an increase in the number of uninsured people and an increase in uncompensated care costs for hospitals, he said.

Under the Maryland bill, health insurers such as Kaiser Permanente and CareFirst would have to pay fees of 2.75 percent of premiums to help fund the reinsurance plan. The health insurance providers fee, which helps fund the ACA, was suspended for 2019 under federal tax legislation, and the state tax would increase previous fees paid by Kaiser Permanente, a health maintenance organization, Middleton said. The state will study the issue of insurer fees for future years, Middleton said. "We are at the eleventh hour right now," he said. "We need to get a bill through."

Wisconsin is the furthest along in creating a reinsurance plan, Justin Giovannelli, associate research professor at Georgetown University, told Bloomberg Law March 26. Wisconsin has enacted legislation allowing the state to apply for a waiver under Section 1332 of the ACA, which allows for changes that are at least as comprehensive and affordable and provide coverage to a comparable number of residents without increasing the federal deficit. The state is holding hearings and taking comments on its draft waiver application for 2019, which it intends to submit shortly, Wisconsin insurance office spokeswoman Elizabeth Hizmi told Bloomberg Law March 27. The $200 million reinsurance program would reduce 2019 premiums by a projected 10 percent, Hizmi said. The average rate increase in Wisconsin's individual market was 42 percent for 2018, she said.

Wisconsin, Maryland, and Hawaii—where a reinsurance bill is being considered—are the states where plans for 2019 are "most likely to go somewhere," Giovannelli said. In other states, bills have been introduced and discussions have taken place about reinsurance plans, but "realistically, it's going to be a relatively small number that move forward" for 2019, he said. Louisiana and Indiana are considering reinsurance legislation, and there is interest in a plan in Washington state, Giovannelli said. But it is difficult for states to come up with funding for the plans, he said.

Alaska and Minnesota already put reinsurance plans into effect, and Oregon has received federal approval to put a plan in effect for 2019, Trish Riley, executive director of the National Academy for State Health Policy, told Bloomberg Law March 27. The NASHP is a group of state health policymakers headquartered in Portland, Maine. Legislation is also pending in the District of Columbia, Rhode Island, and Vermont to create individual mandates requiring people to be covered by qualified health insurance, Riley said. The penalty for not having qualified coverage will be eliminated in 2019 under the federal Tax Cuts and Jobs Act, and health insurers have said some incentive is needed to keep people in the individual markets so that healthy people don't flee.

For many states, "the legislatures are closing fast" to take action for the 2019 insurance markets, Riley said.

COLORADO

Colorado Moving to Protect Unsubsidized Obamacare Enrollees

Colorado is changing the way it will calculate 2019 Obamacare premiums as a result of the federal government not funding out-of-pocket payments for low-income people. But many other states are still sitting on the sidelines rather than change the way they cover Affordable Care Act cost-sharing reductions (CSRs)—government payments to insurers to help people pay out-of-pocket costs. Congress didn't include funding for the CSRs or other market stabilization provisions in the spending bill signed into law March 23. President Donald Trump stopped federal funding of the CSRs in October 2017 because Congress hasn't appropriated the funding, leaving health insurers on the hook. In most states, insurers have been directed or allowed to add the cost of the lost funding to the price of silver tier exchange plans, which reduced at least some of the premium increases for people who didn't receive subsidies for 2018. Ending the CSR

reimbursements is projected to cost insurers $8 billion in 2018, according to the Georgetown University Center on Health Insurance Reforms (CHIR).

ACA premium tax credits are based on the second-lowest-cost silver plans in the exchanges, so adding the cost of the CSRs to silver exchange plans increases the amount of subsidies the federal government must pay for enrollees with incomes between 100 percent and 400 percent of the federal poverty level. In 2017, the CBO estimated that not funding the CSRs would add about 20 percent to 2018 premiums for single ACA policies before premium tax credits were taken into account.

As a result of the higher premium tax credits, many subsidized Obamacare enrollees have been able to buy gold-tier plans that cover more for the same price as what silver tier plans would have cost, or they have been able to get lower-value bronze-tier plans for nothing.

In 30 states, insurers raised premiums for silver plans only in 2018, the Georgetown University blog found. "Silver loading, especially when it's done for on-exchange plans only, protects people who are eligible for premium subsidies," American Academy of Actuaries senior health fellow Cori Uccello told Bloomberg Law March 23. People who make too much money for subsidies are also protected from higher premium increases when the cost of the CSRs is loaded only onto silver plans on the exchanges, she said.

For 2018 exchange plans in Colorado CSR adjustments were made across all plans, both on and off the exchanges, according to the CHIR. Premiums in Colorado's individual market, both on and off of Colorado's exchange, increased 34 percent on average in 2018, Colorado Division of Insurance (DOI) spokesman Vincent Plymell told Bloomberg Law in an email March 22.

But for 2019, the Colorado DOI will require carriers to load the cost of the CSRs onto exchange silver plans, Plymell said. The state doesn't have an estimate for the impact of silver-loading for 2019, he said. Other states took different actions, according to the CHIR report. In eight states, some of the insurers spread the CSR-related premium increases across all silver plans, in and out of the marketplaces. In nine states some insurers spread CSR-related premium increases among the different metal tiers, resulting in higher increases for unsubsidized consumers. Some of those states overlap because insurers adopted multiple strategies.

It isn't clear yet what actions will be taken in states that haven't already loaded the cost of the CSRs onto exchange silver plans. In Oklahoma, where the federal government conducts rate reviews, the state's primary carrier, Blue Cross and Blue Shield of Oklahoma (BCBSOK), has been allowed to include the cost of the CSRs in its rates in both 2017 and 2018, according to Mike Rhoads, deputy commissioner of the state Department of Insurance.

The 2017 rates were reviewed by the Obama administration in 2016, before the CSR payments to insurers were ended by the Trump administration. That meant BCBSOK was able to raise premiums to cover the CSRs even when they were receiving the payments from the federal government. "They were double-dipping," Rhoads said. However, "With only one issuer willing to continue to take the risk of writing this business and given the great uncertainty of the continuation of CSR payments by the federal government during this period, it is reasonable for the two parties (CMS and BCBSOK) to agree to the arrangement," Rhoads said in an email to Bloomberg Law March 23. Oklahoma's premium increase for 2018 was only 8 percent, one of the lowest in the nation, Rhoads said. Rate increases in other states were frequently in the double digits for 2018.

"Blue Cross Blue Shield of Oklahoma accounted for the uncertainty surrounding the federal government's funding of the members' cost sharing reduction benefit in our 2017 and 2018 rates for the individual

marketplace," Kurt Kossen, president, retail markets, for Health Care Service Corp. (HCSC), told Bloomberg Law in an email March 23. HCSC operates the Blue Cross Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

Rates have not been finalized for 2019, Kossen said. "When we establish our rates, we need to make a number of assumptions, including the number of people who will purchase, what and how many services will be used, and what events may occur that could impact what happens in the market. Blue Cross Blue Shield of Oklahoma is proud that we continue to ensure every Oklahoman has a health insurance option each year, and we will continue to work with regulators at the state and federal level to implement policies to help stabilize the market."

MARYLAND

Maryland Hospital Model Surpassing Savings, Quality Goals

The ability of Maryland hospitals to meet cost efficiency and quality of care goals years ahead of time under a statewide hospital payments model has state government and hospital officials excited about expanding the program further.

The extremely positive results are detailed in a new report that shows hospitals in the state have saved hundreds of millions of dollars and readmission rates have plummeted since the state revamped its health-care payment program in 2014.

The report comes as the state and federal agencies responsible for managing government health-care expenditures are looking to further expand the state's unique health-care system. The rosy results also have raised hopes that Maryland could serve as an example of a new delivery model that other states could use to replicate the state's cost saving and care quality achievements. "Maryland has the opportunity to be a petri dish," Gene M. Ransom III, chief executive officer of MedChi, The Maryland State Medical Society, told Bloomberg Law. "You can try these programs out and see if it works."

Launched as the Maryland's All-Payer model in 2014 under a five-year agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS), the updated model included rigorous performance requirements that Maryland's 46 acute-care hospitals had to meet by the end of the five-year period. After just three years under the new framework, performance data from the state's Health Services Cost Review Commission and the Maryland Department of Health show the model on track or ahead of schedule to meet all of its five-year cost-saving goals. The report covers the results through 2016, the third year of a five-year period that ends at the end of 2018. "That's big. That means it's actually working," Ransom said of the report's results.

To be sure, Maryland's system was unique even before it launched the All-Payer Model in 2014. Under what used to be known as Maryland's Medicare waiver, Maryland has been exempted from national Medicare and Medicaid reimbursement principles since 1977. Since then, the hospitals in the state, which all operate as nonprofits, are regulated like public utilities whose rates are set by the Health Services Cost Review Commission.

Maryland's success with the All-Payer initiative is probably in part due to the state's unique history, Ransom says. "It would be very hard to lift this up and drop this in another state," he said. Yet it's possible that Maryland's model could be implemented "in pieces" elsewhere, he said. Under the new agreement with CMS's Innovation Center, a branch of CMS that supports the development and testing of new delivery

models, Maryland hospitals shifted away from "volume-based reimbursement systems" to "global budgets tied to patient populations," the report says. The model aims to improve health-care delivery, improve population health, and limit growth in health-care spending by limiting growth in hospital costs per capita. The update in 2014 turned Maryland from a waiver "into a demonstration," Jim Reiter, spokesman for the Maryland Hospital Association, told Bloomberg Law. "We're a laboratory for how to do things better." For every metric, from spending to readmission rates to hospital-acquired infections, the data show that the model is working, Reiter said.

For example, Maryland hospitals committed to saving at least $330 million in Medicare hospital expenditures during the five-year period from the 2014 to the end of 2018, as measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth. Performance results from 2014 through the end of 2016 show a cumulative savings of $586 million, already surpassing the five-year goal in three years. Maryland has also cut its rate of hospital-acquired conditions in that same period by 44 percent, already surpassing its 30 percent five-year goal. And Maryland is on track to meeting its goal on readmission rates. Since 2013, hospitals in Maryland have steadily reduced readmissions for Medicare beneficiaries, and have done so more quickly than the nation as a whole, the report said. The readmissions gap was closed by 79 percent, putting the state on track to meet its five-year goal.

Since launching the Maryland All-Payer model in 2014, the CMS Innovation Center has entered into similar agreements with other states, a CMS spokeperson told Bloomberg Law. The Vermont All-Payer ACO Model is based on the Next-Generation ACO Model, and extends ACO incentives across the entire state, creating alignment to improve the health of the population and financial stability, CMS said. And the Pennsylvania Rural Health Model establishes global budgets for rural hospitals, testing whether offering rural hospitals more predictable funding will enable them to invest in services tailored to meet the needs of their local communities.

The federal government approved a one-year extension of Maryland All-Payer program in January, allow the state, federal government, and other stakeholders one more year to finalize the next iteration of the agreement. Moving forward, Maryland hopes to expand the current All-Payer Model into a "Total Cost of Care Model" that involves not just hospitals but a wide range of Maryland's health care providers. State regulators are now working with CMS on a framework that is expected to roll out next year and will last until 2029.